

**MONROE COUNTY DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF PUBLIC HEALTH ENGINEERING**

111 Westfall Road P.O. Box 92832, Room 916  
Rochester, New York 14692

**PERMIT APPLICATION**

For

**INDOOR AND OUTDOOR POOLS, WHIRLPOOLS, SPRAYGROUNDS AND BEACHES**

FACILITY NAME: \_\_\_\_\_

FACILITY ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

MAXIMUM HOURS OF OPERATION: **OPEN:** \_\_\_\_\_ AM/PM **CLOSE:** \_\_\_\_\_ AM/PM

**SEASONAL FACILITIES:** EXPECTED OPENING DATE: \_\_\_\_\_

CLOSING DATE: \_\_\_\_\_

**OPERATOR/OWNER INFORMATION:**

OPERATOR / PERSON IN CHARGE: \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

EMPLOYER ID# \_\_\_\_\_ EMAIL \_\_\_\_\_

OWNER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ TELEPHONE \_\_\_\_\_

\_\_\_\_\_ CHANGE FROM PREVIOUS YEAR?

**WORKERS' COMPENSATION AND DISABILITY INSURANCE:**

Check the appropriate lines and submit copies of the following documentation with this application to document compliance with the Workers' Compensation Law:

A. Workers' Compensation and Disability Insurance Coverage **Provided**

Workers' Compensation

\_\_\_\_\_ Form C-105.2 – Certificate of Workers' Compensation Insurance **OR**

\_\_\_\_\_ Form U-26.3 – Certificate of Workers' Compensation Insurance **OR**

\_\_\_\_\_ Form SI-12 – Certificate of Workers' Compensation Self-Insurance **OR**

\_\_\_\_\_ GSI – 105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance

**AND**

Disability Insurance

\_\_\_\_\_ DB-120.1 – Certificate of Disability Benefits **OR**

\_\_\_\_\_ Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers' Compensation and Disability Insurance Coverage **NOT Provided**

\_\_\_\_\_ Form CE-200 Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

**PARTNERS AND CORPORATE OFFICERS:**

List all partners and corporate officers in the operation of the facility. Include vice president(s), secretary, treasurer. Attach additional sheets as necessary.

Name	Title	Address	Telephone

**FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER THE PENAL LAW**  
**Failure to sign this form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code.**

Signature of the operator or authorized official\_\_\_\_\_

Print name of person signing\_\_\_\_\_

Title\_\_\_\_\_ Date\_\_\_\_\_

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**FOR OFFICIAL USE ONLY**

Date Fee Received \_\_\_\_\_

Date Copy of Workers' Compensation Documentation Received \_\_\_\_\_

Date Permit Sent \_\_\_\_\_